Systemic Therapeutic Assessment,

Respite and Treatment

Virginia START

Program Overview

The contents of this manual for the implementation of the START program is approved by the Center for START Services, University of New Hampshire, Institute on Disability (UNH/IOD) for application of the START model.

This Overview is intended to provide a detailed description of the elements of the START program and guidelines for fidelity to the model in the state of Virginia.

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Introduction

What is START?

START (Systematic, Therapeutic, Assessment, Respite and Treatment) is a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment to people with intellectual and developmental disability and mental health issues (IDD/ MH) (Beasley, 2002; Beasley & Kroll, 2002). This model, first developed in 1988, and cited by the Surgeon General's Report (U.S. Public Health Service, 2002), has been used as a basis for the development of services throughout the United States. The goal of START is to enhance the existing system of care, provide technical support and assistance, and fill in service gaps. Emergency and planned clinical respite programs are included in the services provided to meet this important goal.

As mentioned, the original START program was cited by the Surgeon General's report as a model to help overcome disparities in access to effective mental health care for persons with intellectual/developmental disabilities. Outcomes associated with prior applications of the model have been promising. These include significant reduction in emergency service use, increases over time in planned supports/service use, and satisfaction with service experiences for individuals and their families. In a comparative analysis of the TN-START demonstration project in Chattanooga, Tennessee, findings included significant cost savings when compared to individuals who did not receive services through the TN-START program.

Fidelity to the model is essential for success. While START promotes the development of services in the context of the local system of care, essential mechanisms must be in place for effective service delivery. North Carolina was the first statewide implementation of the model

and was therefore selected to partner in the development of this guide that will also help to serve as an instrument for others in the development of START services. In addition to START members, this guide is also influenced by work developed in collaboration with the UNH/IOD Center for START Services, TN-START, the START/ Sovner Center Program, NH START and the CT Woodbridge Project. This version of the START Guide is written to provide support for implementation of the START Model in the State of Virginia.

Mission Statement

The Mission of START is to enhance local capacity and provide collaborative cost-effective support to individuals and their families through exemplary clinical services, and education and training, with close attention to service outcomes.

In meeting this mission, START aims to:

1. Promote the development of least-restrictive, life-enhancing services and supports to the people referred.

2. Provide 24-hour-a-day, 7-days-a-week timely response to the system of care in support of individuals with ID/D and behavioral health care needs. In times of crisis this means immediate telephonic access and in-person assessments within two hours of the request whenever possible.

3. Provide clinical treatment, assessment and stabilization services in the context of short-term respite – both emergency (hospital prevention, transition to community and acute assessment and treatment) and planned (ongoing support for the individual and provider for individuals with complex needs who primarily live with family members or other natural/unpaid supports).

4. Oversee the development and implementation of individual, cross systems crisis prevention and intervention plans.

5. Provide support and technical assistance to partners in the community including but not limited to: Individuals and their families, Mobile MH Crisis Teams, residential and day providers, outpatient and inpatient MH providers.

6. Provide state-of-the-art assistance through a highly trained work force, access to experts in the field, linkages with local and national resources, and the commitment to ongoing consultation and training for both the START programs and their partners.

7. Create and maintain affiliation and linkage agreements with community partners in order to clarify roles and responsibilities, overcome existing barriers in the system, and enhance the capacity of the system as a whole.

8. Provide systemic consultation to work with teams to improve opportunities for mutual engagement, understanding and a team approach that fosters clarity of roles and responsibilities, and cooperation and collaboration in the context of a comprehensive understanding of the people we serve.

9. Assess the needs of the population statewide and work with stakeholders to insure that effective service delivery takes place.

10. Measure outcomes and modify strategies to meet the aforementioned goals.

Who is Eligible for START?

All of the individuals referred to START have a developmental disability. Individuals with a developmental disability (eligible for START) meet the following criteria. "Developmental disability" means a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

b. Is manifested before the person attains age 22;

c. Is likely to continue indefinitely;

d. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and

e. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or

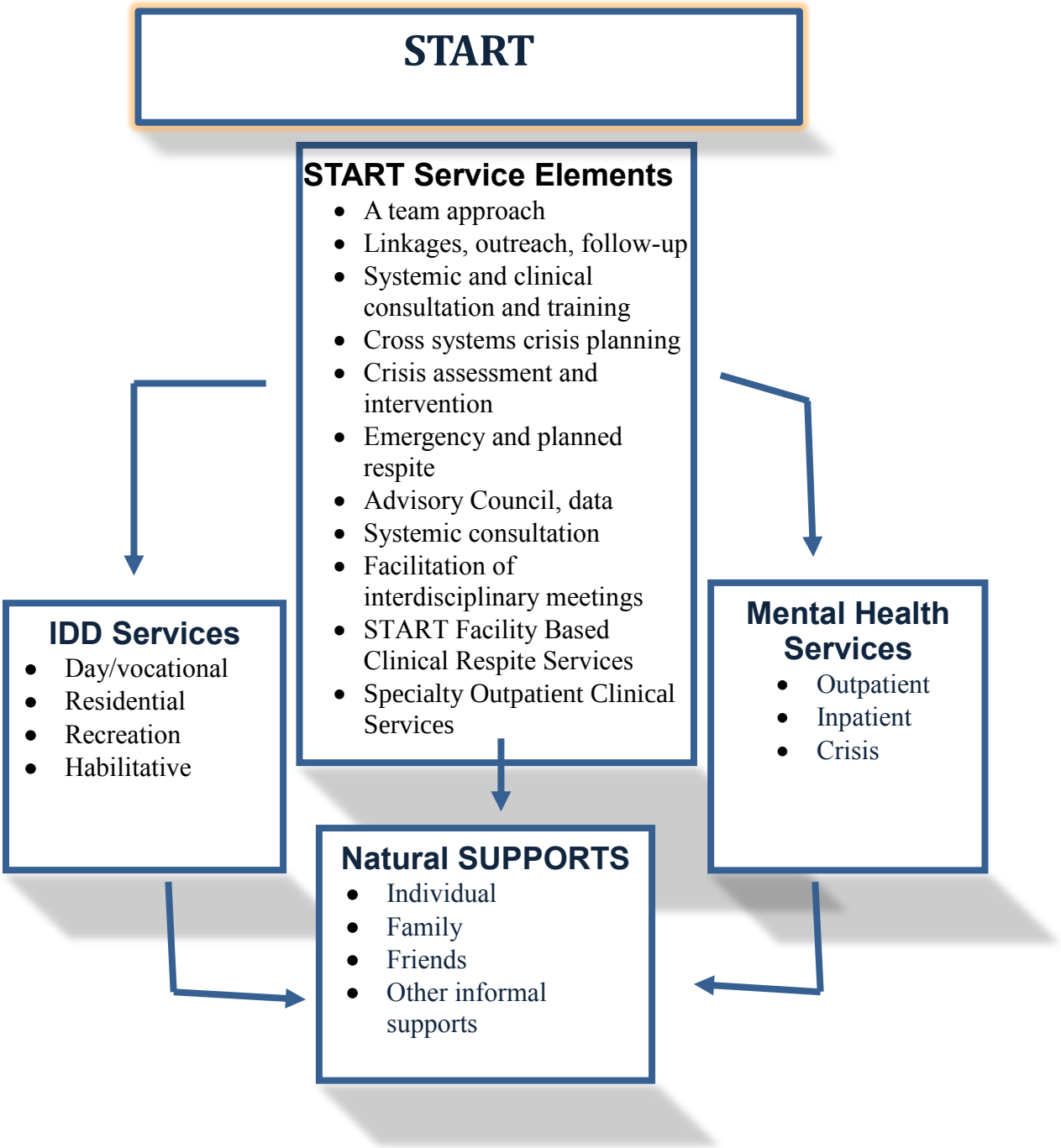
f. When applied to children from birth through four years of age, may be evidenced as a developmental delay.

Emergency intakes occur on an as-needed basis and can be the result of a referral for emergency respite, a request to assess someone in a hospital emergency room or at the request of other emergency personnel. This occurs as soon as possible, often within a few hours of the initial contact to START once the individual has been deemed eligible for the services offered.

(See companion guide with referral forms, policy and procedures.)

START Service Elements

The START system of care program is presented in the diagram that follows:



START Services

The START teams offer both the linkage/clinical team and respite services to be described in greater detail in the pages that follow.

The START linkage team consists of the following personnel: A master's level or equivalent Director who also supervises the Respite Director and the Coordinator Team leader, the START linkage team leader, START Coordinators (who provide 24-hour crisis support, linkages, outreach and consultation services), a psychiatrist who serves as the Medical Director, and a psychologist who serves as the Clinical Director. START linkage teams also affiliate with other experts in the field as needed. Expertise in person centered approaches is essential along with the ability to promote positive behavioral supports as needed.

The START Respite personnel consist of a master's level or equivalent Respite Director, an Assistant Director, nursing support, and qualified direct support professionals.

(See job descriptions in companion guide/policy and procedures manual.) Prior experience in the field and a proven track record of high standards of performance are emphasized in the selection of all START personnel.

Each START team includes local experts to enhance the ability to meet the program's goals. The START Clinical Director is a psychologist responsible for providing consultation and training to Team Clinicians through weekly clinical team meetings, coordinating monthly Cross Systems Clinical Team Meetings, providing consultation to community psychologists and other

providers in the system, identifying community resources, and providing training and technical assistance to community partners and assessments for individuals while at START respite.

The START Medical Director is a psychiatrist responsible for consultation to Team Clinicians, evaluations to guests at START respite and consultation and training to psychiatrists in the community.

A primary goal of all START programs is to promote effective supports and services for persons with ID/DD and behavioral health needs. Service elements aim to accomplish goals to improve access, appropriateness and accountability – the three cornerstones of the START model.

Access to Care and supports: Care must be inclusive, timely and community-based. We provide a systemic approach to link systems and improve access to all services including those of our affiliates and partners.

Appropriateness of Care: Appropriateness of care is reflected in the ability of service providers to meet the specific needs of an individual. This requires linkages to a number of services and service providers, as individual service needs range and change over time. It also requires expertise to serve the population.

Accountability: The third essential element for effective service provision is accountability. There must be specified outcomes measures to care. Service systems must be accountable to everyone involved in the provision of care and this includes funding sources. Outcome measures must be clearly defined, and review of data must be frequent and ongoing. The service delivery system must be accountable first and foremost to the persons receiving care. Outcome measures should account for whether or not an individual's service/treatment plan is

effective over time. Service recipient satisfaction with services is an important outcome measure as well.

Accountability measures should also pay attention to cost. Services must be cost effective, and when insuring access and appropriateness, they can also be treatment effective. The three only conflict with each other when attention to appropriateness of care and the need for access are lacking.

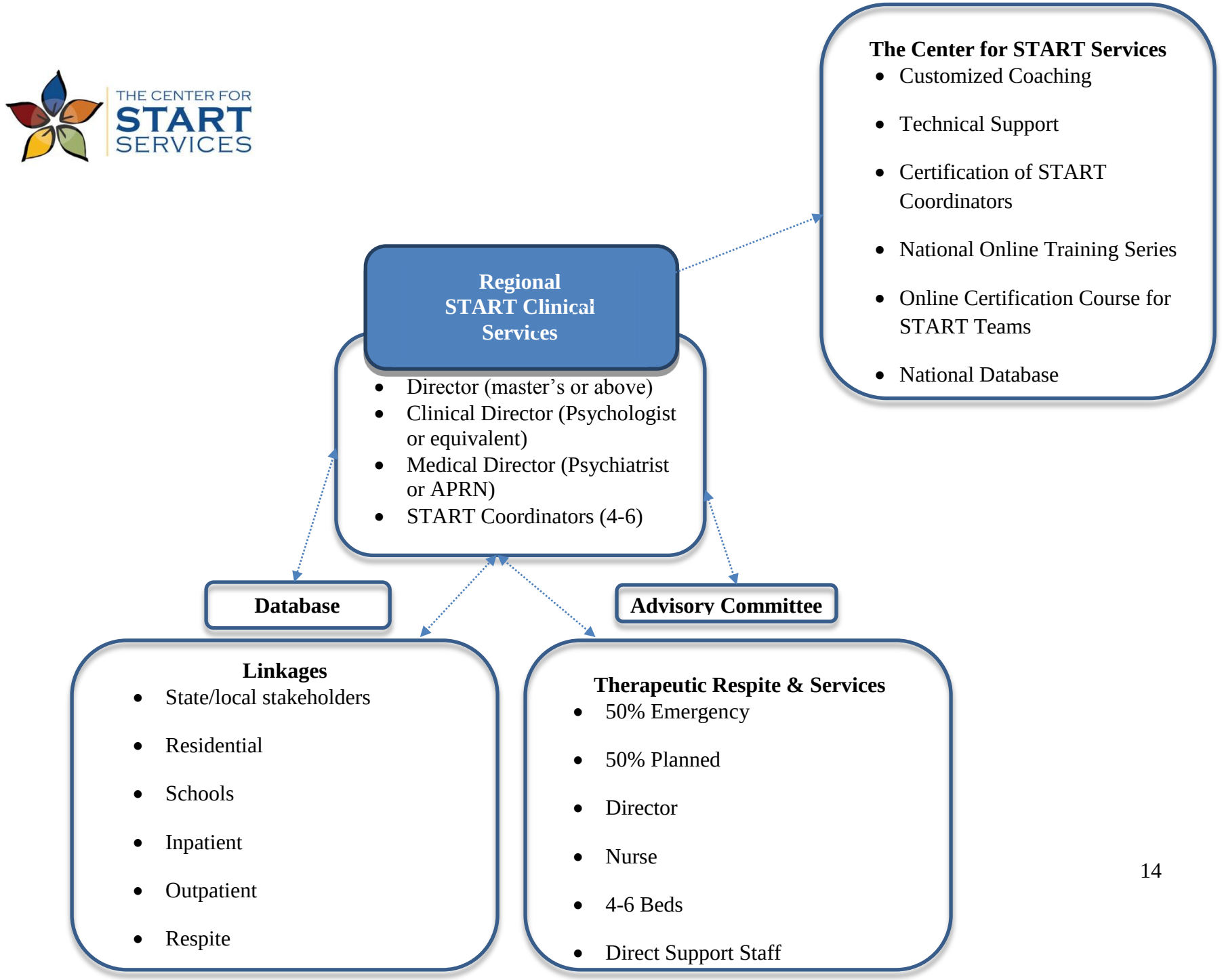
Finally, accountability is a measure of the ability of a system to adapt to changes in individual service needs. Systems must have a structure that can readily adapt to changes in the demands which are placed upon them. Analysis of data must be used as a barometer of where a service delivery system has succeeded and where it must now go. Data should be multi-dimensional and should include both qualitative as well as quantitative measures.

The START model emphasizes that appropriate services are to be readily accessible and provided in a timely fashion. Data collection and review determine the need for modification of resources to comply with this requirement as needed. The program is designed to evolve over time to meet the needs of the population and the system of care.

START Service Elements

In order to promote effective services and supports the START Program service elements include:

- An ongoing team approach
- Mobil crisis response and services
- Affiliations/linkages/outreach and follow-up, include in description of linkages with mobile crisis teams
- The role of START to support community placement and prevent facility placement
- Systemic and Clinical consultation, positive behavior support
- Training/Clinical Education Teams
- Cross systems crisis prevention and intervention planning
- Emergency assessment and response
- Clinical assessments and service evaluations: case managers, roles and responsible
- Steps for implementation now
- Emergency and planned respite: explore other regions 6 beds
- Advisory Council/ongoing assessment of service outcomes (data, documentation)


The Center for START Services
Customized Coaching
Technical Support
Certification of START Coordinators
National Online Training Series
Online Certification Course for START Teams
National Database
Regional START Clinical Services
Director (master's or above)
Clinical Director (Psychologist or equivalent)
Medical Director (Psychiatrist or APRN)
START Coordinators (4-6)
Database
Advisory Committee
Linkages
State/local stakeholders
Residential
Schools
Inpatient
Outpatient
Respite
Therapeutic Respite & Services
50% Emergency
50% Planned
Director
Nurse
4-6 Beds
Direct Support Staff

The START Team Approach

Active communication and collaboration begins with the START team itself. There are various methods used that in spite of the fact that START team members operate in the field independently, the entire team works together to support individuals and the system. Following are some of the protocols that are required for START programs:

Morning Triage Calls

Members of the team participate in a Triage call each weekday morning. Triage calls provide a time for START Coordinators to review any calls they may have received since the previous day. The Respite Director or designee provides updates on the guests at respite and review respite admissions/discharges as necessary. This is also a time to discuss crisis/emergency needs of individuals referred or already part of the START program and receive direction/support from supervisory staff. Follow-up for crisis contacts is also determined at this meeting along with dissemination of intake assignments for emergency referrals.

Staff Meetings

Each START team conducts weekly staff meetings to review systems related issues, respite and other service elements.

Recurring Team Meetings are intended to ensure all necessary information is communicated to the entire START Team as well as provide meaningful dialogue regarding the care and treatment of individuals supported by START and coordination and support of their respective systems. In doing this the following agenda items should be included in all START Recurring Team Meetings:

1) Review of individuals on active caseload who are experiencing difficulties, crises,

significant events and/or are experiencing circumstances and situations that may lead to crisis events. This includes individuals whose early stages of crisis intervention may have occurred. Review status of guests at respite and any upcoming plans for discharge;

2) Review planned respite schedule for the week and any openings;

3) Review any new administrative/operations procedures, policies, etc. and/or problems/issues with current processes that may warrant further discussion and/or changes to current operational processes;

4) Review individuals on waitlist (if applicable) as well as recent referrals; and

5) Review any significant administrative or procedural problems, changes, etc.

Peer Review

Peer review is an essential component of the program's internal process for quality assurance. In addition to external audits and reviews, START completes internal peer reviews to improve crisis plan development, respite discharge summaries and maintenance of medical records. START Coordinators, Team Leader, Regional Director, Clinical Director, and/or Respite Director will participate in peer review as deemed appropriate by the Regional Director. Peer reviews occur a minimum of quarterly.

Live Supervision

Live supervision techniques are part of the core training and supervision protocol for all START personnel and includes review of videotaped meetings and activities to improve the skills and effectiveness of the team.

Linkages, Outreach and Follow-up

Formal affiliation/linkage agreements are a key to the START program. These agreements link the START program with mental health and medical providers, inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists, experts in the field, etc.

Crisis Support Continuum Development: START develops relationships with community partners in order to bridge service gaps and improve service outcomes. This includes development of affiliation agreements and collaboration with Mobile Crisis Management and First Responders for increased diversion, collaboration with hospitals regarding admittance discharge planning and transition, as well as Crisis Plan Development and Emergency Respite.

Minutes from Meetings: Minutes from all meetings are taken by START team members (usually the START Coordinator but may also be other team members as needed) as part of their contribution to the linkage approach to care. This includes goals and objectives of the meeting and the plan of action and follow-up. Notes from each meeting are disseminated by the START team to all who attended the meeting within 24 hours or the next business day after the meeting occurred.

Affiliates are partners with signed linkage agreements whom START maintains frequent and ongoing collaboration with as part of the infrastructure. This includes an affiliation with the National Center for START Services at the UNH/IOD through our work with Center for START Services Director Dr. Joan Beasley, which allows the program to offer trainings and linkages with other START teams nationally.

Further, START has numerous partners providing services in the community; partners are defined as those agencies with whom START does not have a formal affiliation agreement, but with whom they work in collaboration.

In adhering to the goal of systems accountability, the approach is adaptable to the changing needs of the people and systems supported.

Outreach serves to support the systems of care. START personnel remain in contact with service providers and individuals to insure that they continue to receive effective services. This includes home visits and phone contact to remain in touch so that needs are responded to in a timely fashion.

Follow-up is another important element of the START approach to service linkages. The project follows any individual referred to START for up to a year or more as needed. Individuals placed on the inactive status will remain part of the system and reactivated should the need arise.

Another important service provided by START is planned outreach. We learned from prior research from the START program in Massachusetts, that the most overwhelmed systems are the least likely to contact the START team, increasing the likelihood of eventual emergency service use. As a result, all active cases receive at least monthly phone contact to check in and insure that the individual continues to do well.

START Coordinators maintain ongoing contact with family members and other caregivers. Follow-up meetings are scheduled to evaluate the effects of treatment strategies, update crisis prevention plans, and foster active communication among providers and with direct caregivers.

START Coordinators and other members of the clinical team provide outreach support through home visits, assistance in attending appointments with mental health providers,

attendance at admission and discharge planning meetings for psychiatric inpatient stays and emergency and planned START respite stays, visits to residential and day providers to provide consultation and training, and other community-based contact as needed and available.

Systemic and Clinical Consultation and Training

Systemic Consultation is a core service element for the START model, and was first developed by the program's founder, Dr. Beasley. All START Coordinators are trained to provide a systems approach to team consultation. Based on the work of Salvador Minuchin, START staff members incorporate an understanding of the context/structure in which the system makes decisions and implements action to assist a team in problem solving and service planning. START Coordinators receive ongoing supervision in order to improve their own skills to provide a systemic approach that encourages engaging all members of the team, the use of functional analysis techniques, and fostering active communication and collaboration of all team members.

Clinical Consultations/service evaluations: Members of the START Clinical team include experts in the field of psychiatry and psychology working with individuals with ID/DD and behavioral health needs. State-of-the-art instruments are used to collect data. START respite staff are trained and supervised in data collection methods. In addition, START Coordinators provide an analysis of individual records and service outcomes through the development of comprehensive service evaluations.

Clinical Education Team Meetings

The START Clinical Education Teams (CETs) meet monthly. This is a forum designed to improve the capacity of the local community to provide supports to individuals with ID/DD and behavioral health needs through clinical teaching.

The team consists of START Coordinators, members of ID/DD Treatment/Service Community. Members from the local community of service providers are often invited and included in the process. These partners include, but are not limited to, local mental health centers, emergency services and inpatient providers if possible.

The goal of the CET is to help service system providers learn how to best support people while improving the capacity of the system as a whole through information sharing, learning, and collaboration among team members.

Because this is an educational forum, each individual presented will have his or her identity hidden to protect confidentiality. The training is not so much about the person presented, but rather descriptions of the problems faced, strengths and resources, as well as diagnosis and treatment information so that the individual serves as an example for discussion and further examination. However, it is expected that the discussion will generate ideas about possible remedies to improving services and clinical outcomes to explore for the individual presented.

Each month, up to two people will be reviewed. START Coordinators will initially select individuals but later reviews may come from community partners. The meetings will take two hours to complete each month. START Coordinators will have a summary of recommendations and will provide follow-up information to the team at subsequent meetings so that all can learn from the process.

These education teams will not involve parents or the individual. This is training rather than consultation.

Training for Providers/Families: All members of START are available to provide training to providers and/or families when requested. Training for the Cross Systems Crisis Plan (CSCP) or respite recommendations are common topics of trainings completed. However, other specialty trainings are completed by the Clinical or Medical Directors, or Program Director, depending on the request or topics involved. Training network providers helps build education and capacity within communities. Offering training is essential in the framework to support community capacity in working with individuals with ID/DD.

Cross Systems Crisis Prevention and Intervention Planning

Another essential element of START services is the Cross System Crisis Plan (CSCP). The CSCP is an individualized, client-specific written plan of response that provides a specific, clear, concrete, and realistic set of protective supportive interventions that prevents, de-escalates and protects a client experiencing a mental health or behavioral health crisis. The goal of the CSCP is to identify problems that have or may arise and map out a strategy that offers the tools for the circle of support to assist the individual to address problems and prevent crises from occurring

START Coordinators facilitate individual Cross-Systems Crisis Prevention and Intervention Planning meetings at least once a year and after each crisis. Whenever possible, the START Coordinator, the individual, members of the mental health service team (which could include an outpatient therapist, a representative from the clinical home provider, psychosocial rehabilitation provider, etc.), members of the developmental disabilities service team (which could include the targeted case manager, residential and day program providers), and the individual's natural supports (family members, friends, and other interested parties) meet to develop a plan to assist the individual and his or her caregivers during times of difficulty. A full and comprehensive Crisis Plan should be written within 60 days of completing the intake.

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. Crisis service use most often follows severe maladaptive behaviors on the part of the individual, e.g., assault or property destruction. Crisis prevention planning can provide a strategy to assist an individual and the people who provide support to better cope in times of difficulty.

There are four goals of the CSCP process to accomplish this task:

1. Reaching an understanding regarding communication of needs through maladaptive behaviors. A primary goal of the collaborative planning process is for all concerned parties to reach consensus regarding what an individual may be communicating through maladaptive behaviors. Family caregivers and other people providing support and assistance can better introduce alternative strategies to help an individual get their needs and wishes met when they understand the "meaning" of a given maladaptive behavior. When effective, this strategy helps to prevent a crisis from occurring.

2. Developing/improving upon coping strategies for the individual and caregiver. The CSCP outlines options for individuals and their caregivers to cope with feelings or difficulties that may increase the likelihood of maladaptive behavior(s) if not addressed. For example, the plan may delineate "early warning signs" that may indicate an individual is experiencing anxiety. Based on what is known about the individual, the plan outlines relaxation techniques to assist in reducing the person's anxiety.

3. Preventing the system from going into crisis. The roles and responsibilities for specific professionals and service providers are delineated. The CSCP helps service providers respond more effectively in times of crisis. It is helpful when the plan is as specific as possible in defining who should be contacted and when. The plan may also include important facts about the individual to help service providers contacted to better assist the caregivers. To ensure that the plan is taken seriously, each plan is signed and approved by all involved parties.

4. Simplify access to services. It is important that access to emergency services be as easy as possible. For example, we provide a list of services and important contacts to families and caregivers. Families and other direct support providers have ready access to the list as part of the CSCP.

Crisis/Emergency Assessment and Intervention

Another important service provided by the START team is to assist during times of difficulty. In order for our community partners to be able to reach START, there is always at least one designated START Coordinator on call for each respective region 24 hours a day, 7 days a week. The Program Director or Clinical Director serves as the back up for the on-call system. Typically the on-call responsibilities rotate between each START Coordinator. The Program Director maintains the schedule for the on-call system and ensures the region is covered.

If assistance is requested from START there are several things that must occur. The START Coordinator will:

1. Identify the problem or reason for the call.
2. Notify the person on the call that START will assist.
3. Consult with all parties involved if necessary in order to determine nature of the problem and what assistance will be provided.
4. Assist the person with developing a safety plan to ensure the safety of all involved.
5. Determine what assistance can be provided.
6. Present information to START clinical team during triage calls.
7. Follow up to determine if other assistance is necessary.
8. It is important to never communicate the concept that there is nothing that can be done to help. Even if we are able to link to a more appropriate resource, that is a success. If capacity or waitlist issues exist, START will still be able to offer telephonic consultation.
9. Emergency calls come from a variety of sources. START may receive emergency

calls for assistance from the following, but not limited to: Hospital Emergency Departments, Mobile Crisis Teams, Clinical Homes, Community Providers, Families, Law Enforcement, and the individuals needing assistance or experiencing the emergent situation.

START is expected to respond to a crisis call in a timely fashion, and to assess emergency service needs through face- to- face evaluations whenever possible. Adherence to the model requires immediate telephonic response and onsite evaluations within two hours of the initial contact to occur whenever possible. Review of outcomes helps to determine if there are obstacles to this important goal being met. It is the role of the funding sources, advisory council and START program to assess the ability of a timely response and to propose and implement remedies when needed.

All instances of crises for individuals supported by START should include next-day follow-up by START clinical staff assigned to the individual that experienced the crisis to learn the resolution of the crisis and if not already known the effective strategies for stabilization and resolution. If the crisis outcome included placement in a higher level of care such as a mental health inpatient unit, next business day follow-up should include a face-to-face meeting at the hospital or facility to discuss goals of the admission and discharge planning. START will assist in the engagement of all stakeholders, caregivers and providers in the treatment and service planning process.

In all circumstances of crises for individual eligible and/or currently supported by START, the information obtained from the response to the crisis should be included and/or considered when developing/revising the individual's cross-systems crisis plan. Each person involved with START will have a CSCP that should be reviewed with the service team and revised as needed, especially after an emergent situation has passed.

In most situations, when a crisis (emergency) call is received, an START representative will seek to complete a face-to-face assessment/consultation within two hours of the request whenever possible. There will be situations when this will not occur, such as when the person experiencing an emergent situation is placed in a different setting such as another respite facility or hospital bed, or when the person is deemed to not be an appropriate START service recipient. All calls and interventions will be documented on an Intervention Outcome form. It is the hope to assist all callers and provide response/intervention as necessary for each person.

Prescreening for In Home Crisis Stabilization Services:

The goal of the START team is to provide as many supports as possible in the person's natural setting. However, this must be safe for all involved so the prescreening abilities of the team are key. For the most part, START coordinators will prescreen for in home services based on the established criteria in an individual's cross systems crisis plan. In some cases, when the individual is not known to our system, arrangements for in home crisis stabilization supports can be made. This usually takes place during business hours when other supports and information is available. However, the team will assess the ability to provide these services on a case-by-case basis.

Prescreening for Emergency Respite: When determining clinical appropriateness for eligible potential guests for START Crisis Respite, START Coordinators confer with the START Director, START Respite Director and START Clinical Director (as appropriate) regarding the current clinical presentation and needs of the potential guest(s). Dialogue about the admission will focus on ensuring safety of the potential guest, staff and other guests in the home as well as the likelihood of the potential guest stabilizing in a community-based setting. If the team feels that safety needs are met, the individual has a high probability of stabilizing

during admission, and there is bed availability, the team will likely recommend admission.

If the team is concerned about safety for the individual and others and/or the likelihood of stabilization of the potential guest appears to be low, the START Director, Respite Director and Clinical Director will confer to determine if the concerns with safety and/or stabilization may be alleviated or better dealt with the confirm the potential guest's admission. The final decision to confirm or deny the potential guest's admission will rest with the START Director based on information and feedback provided by the team including the Clinical Director and START Medical Director (as needed). When a request for START Emergency respite services come for eligible potential guests is denied, the denial must be recorded by the START Coordinator on the START Data Template as either a denial due to:

- Higher Level of Care Needed (Psychiatric)
- Higher Level of Care Needed (Medical) OR
- No Emergency Respite Beds Available

When demand for crisis respite beds exceeds the available resources, all potential guest(s) for crisis respite admission will be continuously evaluated and triaged according to the most urgent need for crisis respite, with the potential guest with the most urgent need receiving the offer of the crisis respite bed.

Should other potential guests present with urgent needs for crisis respite without available beds in the respective region, the START Director will inquire and collaborate with the other START Directors about emergency respite availability and potential out-of-region admission. The remaining potential guest(s) requesting crisis respite admission will be continuously reevaluated regarding their need for crisis respite; as crisis respite beds become available they will be offered to those potential guests with the most urgent needs.

For any potential guests denied admission to emergency respite that remain in community settings, the START Clinical Team will provide ongoing crisis consultation and support as well as link the individual to available community resources.

Emergency Meetings: It is often necessary to participate in emergency team meetings when someone is experiencing an acute psychiatric emergency or behavioral challenges. Emergency meetings are often facilitated by START Coordinators to ensure all team members are informed of and involved in the issues surrounding the emergency in order to better support the individual.

START Mobile In-Home Community Support Services

Each START team will have the capacity to provide in-home supports in as part of their compilation of services. In-home supports are designed to assess and stabilize an individual in his or her natural setting. This service is part of the mobile crisis capacity of START, and the START Coordinator determines the need for supports. In most cases the provision of in-home supports is planned with the full knowledge of the individual and the setting. However, the provision of supports may occur seven days a week and will depend on the person's crisis plan and his or her need for services. Once contacted, the team will be expected to have in-home supports in place within two hours of the plan to provide services. This means that the mobile in-home supports team will be located throughout the region so that they can provide timely support. The goal of the in-home supports is to assist the person's current support provider or family in implementing successful strategies to prevent the exacerbation of a problem, implement crisis intervention strategies and provide observational assessment of the person and their circumstances. The in-home supports will be provided by qualified and trained personnel who will be part of the local mobile crisis network which is made up of START Coordinators and on-call clinicians who will provide assistance and support as needed. It is expected that services will be provided for up to 72 hours per intervention period. Prior to the end of this period the individual will be reassessed by a START Coordinator and the team will determine the follow-up services and supports needed including planned or emergency respite at the START Clinical Respite facility if needed.

START Facility-Based Clinical Respite Services

START facility-based respite is designed to provide active therapeutic supports to individuals determined to require out of home evaluation, stabilization and/ or treatment implementation. Close collaboration with the person's home support system is an essential to the success of the program.

The respite site: In adherence to the expectation of effective service delivery, START respite requires a proactive clinical and service approach along with the ability for those in need to access services with regard to proximity of the facility and design of the program space. Therefore, START respite programs should allow for enough space to provide a therapeutic environment for all guests. This requires enough community space for programming, meeting space for staff and community partners and individual bedrooms for guests. The surroundings should be home-like but clinically appropriate to support individuals who may need limited access to daily items, such as sharps, for safety. The staffing pattern must allow for individualized programming and personnel must be trained to support potentially volatile individuals. The mission of the program also requires that the respite facility be geographically accessible to those in need so that the location should not exceed a one-hour travel time under ordinary travel conditions for most eligible guests. This may not be possible for all START service users, but should be a target for locating respite so that most of the time travel time and distance is not an obstacle to access. *Evaluation of the respite programs will include the adherence to these guidelines and remedies should be requested if not in place.*

START respite is a community-based therapeutic program that provides assessment and supports in a highly structured setting. The START respite program requires clear emergency back-up policies and procedures and a highly trained staff to provide the needed supports and

service to guests at respite. It is closely linked with the START Clinical team and includes evaluations by the START Medical and Clinical Directors in addition to ongoing collaboration with START Coordinators.

The START respite program provides community-based, short-term respite exclusively for potential guests eligible for and enrolled in the START program experiencing acute, chaotic and/or needs that may otherwise be identified as a "crisis." The intent of this respite with the START program is crisis prevention, stabilization, assessment, treatment and tracking via providing a change in environment and a structured, therapeutic community-based home-like setting.

All guests of the START respite home are visiting the home because they were recently or are currently experiencing a crisis or have demonstrated a high propensity for crisis situations. Therefore the home is designed to create a safe environment for assessment and stabilization. Each START respite home has private bedrooms, space for programming and meeting, a fenced-in yard to allow for people to leave the home without injury, and a sensory room which can offer a quiet area when needed. The space must allow for both integrated programming and individual support as needed. The program should be located in a neighborhood with access to ordinary community activities. However, in the program, the individuals are guests, and do not have unsupervised access to sharps, flammable materials, cleaning supplies, or food to insure safety. Unless approved, they do not have unsupervised community access. This is a therapeutic setting and is not intended to replicate a home environment.

Planned Respite

Three of the beds in the six-bed respite facility are designated as "planned respite beds." Planned respite beds at START are intended to serve people who have not been able to use respite in more traditional settings due to ongoing mental health or behavioral issues. Families and others participating in the program must be approved as eligible for these services, but once approved, they schedule visits as needed (and when available).

The goals of planned respite include: provide a break from the daily life experiences of both the caregiver and guest, monitor the effects of treatment, coping skills training, crisis prevention, positive experiences to look forward to, training to providers and caregivers, and increased recreational opportunities for individuals who often lack the ability to access these supports in the community.

Potential guests scheduled for START planned respite services are required to have confirmed transportation (as documented on the Care Provider Information Contract) from their permanent residential setting to the respite home prior to admission and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Regional Director and/or Respite Director (as applicable) must approve any transportation provided by the START Team.

Length of Stay

START planned respite services are designed to be very short-term and generally will not exceed five consecutive calendar days. As START planned respite services are limited to two beds in the home, guests may receive no more than 36 days of planned respite per calendar year with the recommendation of no more than one visit per month. The START Director in conference may grant exceptions to these limits with the respite director and clinical director.

Planned Respite Visits

Planned respite visits do not include an overnight stay. Planned respite visits are provided to any START service recipient and are not restricted to people living with their family. An individual can visit respite for dinner, a recreational activity, or to just "check in" for a few hours. Some families visit respite with the guest to become familiar with the facility and the staff prior to scheduling an overnight visit.

Scheduling

The first planned respite admission is facilitated by the START Coordinator in collaboration with the Respite Director or designee. Following the first admission to planned respite, all subsequent admissions to respite are scheduled between the families and the START Director and communicated with the START Coordinator.

Policies and procedures for planned respite include referral information, crisis plan, items needed at the time of a guest admission, house rules, guidelines for admissions meetings, information needed in service record, meetings and activities while at respite, assessments at respite, collaborative contacts, the role of the START Coordinator, daily activity schedule and instructional guide, data collection and documentation, admission and discharge summary form, and protocols.

Activities, services, assessments and data collection for guests in the START respite home are driven by information provided in the respite admissions summary, cross-systems crisis plan and any and all other supporting documentation or dialogue provided prior to or at admission. All activities, services, assessments and data collection are individualized and dictate much of the daily activities schedule. Although there are certain activities that take place as part of regularly scheduled programming the needs of the guests guide the specifics of these

activities. All activities are based on an individual's goals/objectives and tailored to the individual's needs. The program policy and procedures guide will also document assessments and protocols for implementing them while at respite.

At the conclusion of a guest's stay, staff will meet with the guest and their caregiver about the visit, discuss what was learned and answer any questions the guest and/or caregiver may have. Guests are also encouraged to complete an anonymous survey about their experience while at respite.

Planned respite discharge summaries are written quarterly and will be sent to the START Coordinator for distribution to the guest's team within one week of their most recent stay.

Emergency Respite

Emergency respite services are provided at the START respite facility located in each region. Three beds in each six-bed respite facility operated by START are designated for emergency respite purposes. Unlike planned respite, which is offered primarily to families, all START service recipients can access emergency respite as needed. Emergency respite is designed to provide out-of-home housing and services for people who, for a short period of time (suggested 30 days or less), cannot be managed at home or their residential program.

The goals of emergency respite include: clinical assessment, hospital diversion, stabilization, reunification with home and community settings, training to caregivers and providers, collaborative contacts/ consultation with treatment teams, step down from mental health inpatient services, positive social experiences, behavioral support and planning, assessment and refinement of treatment approaches, coping skills development and enhancement, and family support and education.

A list of forms and protocols is documented in the policies and procedures companion guide.

Prescreening and Coordinating Potential Admissions

Crises tend to occur at all hours of the day and all days of the year. As such, scheduling emergency admissions to the START respite home may necessitate a significant amount of planning take place within a very limited timeframe. Planning and troubleshooting for emergency admissions occurs within one hour of the request through direct contact between the START Coordinator and the Respite Director/designee. In many cases, potential guests for START emergency respite are new to the program. When coordinating guests' emergency admissions the assigned/on-call START Coordinator will contact Respite to discuss the clinical

needs of the potential guest, bed availability and expected length of stay (not to exceed 30 consecutive days per admission).

It is the responsibility of the START Coordinator to collaborate actively with the Respite Director throughout the admissions process. The final decision about admissions occurs between the Respite Director/Designee, and START Coordinator under the supervision of the Director of START Services. If needed, consultation with the START Clinical or Medical Directors will occur to make the final determination with regard to the appropriateness of the admission.

General Rules for times/dates on admissions:

- Admissions for Crisis respite generally occur between the hours of 8:00 AM and 7:00 PM Monday through Friday.
- Previous guests of the START respite home in need of emergency respite services may be admitted outside of the designated admissions hours.
- These admissions will be considered on a case-by-case basis.

Potential guests scheduled for START emergency respite services are required to have confirmed transportation from their permanent residential setting to the respite home prior to admission and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Regional Director or Respite Director (as applicable) must approve any transportation provided by the START team.

Admissions Meeting

Upon or prior to arrival at the START respite home guests, their care provider/transport and their assigned/on-call START Coordinator participate in a brief meeting to review chief complaints and the goals/objectives identified in the respite admissions summary and other

provided documents/forms as well as identify the services, assessments and data to be collected during the guest's stay. The START respite team facilitates this meeting. Other participants in the respite admissions meeting may include the Respite Director or Lead Respite Counselor, Respite Counselors, Clinical Home provider, Residential Provider, etc.

The START Coordinator will participate in all START crisis respite admission meetings. A START Coordinator must visit the individual while at respite at least weekly to assist respite and help evaluate progress and service needs.

Documentation

START Respite staff members complete relevant and appropriate documentation for all guests in care. Many of the forms selected are specifically designed to meet the needs of the program, while some more generalized forms are agency or state-required forms. Each form selected for documentation with START has been carefully reviewed and approved by the Respite Director and START Team. It is imperative that all documentation identified be completed prior to the end of each Respite Counselor staff's assigned work shift.

The forms designed for use with START program are identified in the companion guide.

Guests of START Emergency Respite will have an approximate discharge date identified upon admission. This date will be determined by goals and objectives established with the team at intake. This date may require adjustment based on the individual's progress.

All guests receiving START Emergency respite will have weekly discharge planning meetings facilitated by the respite team and the respective START Coordinator. These meetings will provide a forum for dialogue to assess significant events, progress toward goals as well as discuss the potential discharge date, transition to home environment and any necessary follow-up care.

The weekly collaborative meetings are required and full team participation is needed in order to maximize the effectiveness of the respite stay and prevent the need for future crisis services whenever possible. Meetings will include participation by the clinical home provider, the home case manager or care coordinator, residential provider (if applicable), family member/legal guardian and any other applicable team member. Meetings may occur face-to-face, via teleconference or a mixture of the two. The START Coordinator will attend all meetings. The START Coordinators must be present for face-to-face meetings whenever possible.

Guidelines to assessment of target behaviors: Because people are admitted to START after incidents have occurred, there may be an absence in the occurrence of target behavior while at respite. This should not preclude assessment of what may have resulted in difficulties, the provision of clinical and psychological supports and dialogue and discussion with the guest's home setting to assist in preventing future difficulties once the person returns home. In order for this to occur, it is essential that ongoing collaboration between respite, START Coordinators and home providers occur on an ongoing basis in order to get a better understanding of the conditions that precipitated the emergency respite admission.

At the conclusion of a guest’s stay at the START respite home, respite staff in conjunction with the assigned START Coordinator will meet in person with the guest, their caregiver and clinical home provider during a discharge meeting about services delivery and process what occurred, what was learned and answer any questions the guest, clinical home provider, and/or caregiver/transport may have. Guests are also encouraged to complete an anonymous survey about their experience at the respite home.

Following discharge, the Respite Director will collaborate with Respite Counselors, START Clinical Director and assigned START Coordinator to develop a Discharge Summary of the guest's stay to be completed and disseminated no later than one week after discharge. The Discharge Summary is then forwarded to the START Coordinator as along with relevant data collected on behavior tracking, etc., for distribution and dialogue with the individual's clinical home and relevant care providers.

START emergency respite services are designed to be short-term and generally will not exceed 30 consecutive calendar days. A measure of success in improving service outcomes is the reduction of readmissions over time. As such, a guest's length of stay for crisis respite may be extended to ensure adequate data and maximum therapeutic benefit. Any decision to exceed the above-identified maximum length of stay will be determined by the START Director and Respite Director.

Advisory Council, Data/Reporting

Critical to ensuring effective service delivery in the context of the START program is the Advisory Council. It consists of stakeholders, experts and personnel from START. The Advisory Council meets quarterly to provide support and review progress and future directions. The Advisory Council enhances our capacity to remain accountable to everyone involved.

Data Collection and Analysis

START collects data in a variety of levels including, but not limited to, individual demographics, service event/encounters, respite services and outcomes, and administrative activities. It is essential that all START programs continue to evaluate service needs and outcomes through the continuous process of data collection and evaluation both for reporting purposes and to improve service effectiveness over time. This is a core element of the START philosophy – you must continuously measure what you are doing and for whom you are doing it. The protocols for data collection are found in the policies and procedures companion guide.

Quarterly Reports

The START program reports select data on a quarterly basis to the contracting and oversight entities. The format for these reports is included in the companion guide. The START Program Director is responsible for aggregating the required data and submitting the reports to their respective stakeholders and funding sources.

Annual Reports

All START programs compile an annual report to review with their Advisory Council and other stakeholders. From analysis and discussion of the outcomes documented in the report, the team develops goals and objectives for the project in the coming year. The START program

submits an annual report on the activities of the respective fiscal year to the NC Division of Mental Health, Developmental Disability and Substance Abuse Services.

The annual report is comprised of the statewide activities of START and its completion is the responsibility of the START Program Directors in collaboration with Dr. Beasley who provides technical support to the teams throughout the year.

Specialty Outpatient Clinic Services

Each region will provide outpatient clinic services to individuals with complex needs. Services will include: psychiatry, neurology, nursing, psychology and social work supports with linkages to primary care, dentistry and OT services. The team is comprised of experts in the field. The goal is to provide a clear and comprehensive and treatment formulation for up to one year with transfer back to local providers. START Coordinators are active members of the treatment team, link the system, attend appointments with other informants, and insure discharge and placement back to local systems of care.

Clinics will provide services and be primarily be reimbursed via third party insurance whenever possible. The clinics will require and receive enhancements for services that are not reimbursable through insurance to include: multi modal case review of complex individuals, consultation, training, and outreach visits as needed.

Data Required

START requires continuous collection of information and analysis of the population supported along with outcomes associated with service delivery in order to meet our mission. Following is a list of data required for quarterly reports to the state or local entity along with the Advisory Boards for quarterly and annual analysis and planning. These are minimal requirements and will be enhanced by the local entities operating START services.

People served /referrals

- Gender
- MH Diagnosis at time of referral (distribution)
- ID Diagnosis (distribution mild, moderate, severe, profound)
- Medical Diagnosis at time of referral (distribution)
- Primary reason for referral
- Inpatient hospitalization total number of people
- Rates in hospital (community based): range, mean, median, and mode
- Developmental Center Admissions total number of people
- Number of days in Developmental Center after admissions
- Total number of admissions to state hospital
- Rates in state hospital: range, mean, median, and mode
- Recidivism rates to ERs: range, mean, median, and mode
- Average age
- Who referred (distribution)?
- Where from (Local funding agency/authority) (distribution)

- Total number of people living with family:
- Total number of people living in other settings (distribution)
- Total number of people transitioned out of state hospitals
- Total number of people transitioned out of developmental centers

START Coordinator Services

- Total number of people served this fiscal year, and since beginning
- Average caseload per month (active and inactive)
- Average *active* caseload per month (include all services, contacts etc. in activity number)
- Average number on waitlist per month
- Distribution of service types per month (respite: include type, outreach, crisis contacts, intakes, face-to-face vs. other, crisis planning, professional consults – include type, i.e., psychiatric vs. psychology – CET reviews, prescreening)
- Travel time per month average
- Crisis contacts after hours and weekends vs. bus hours
- Crisis contact outcomes (admissions, remained home, admitted to respite)
- Crisis contact travel (average number of hours per crisis contact)
- Planned contact outcomes (type of meeting, crisis plans, intakes etc.)
- Planned contact travel (average number of hours in planned contact)
- Response time in hours to crisis calls (range, mean, median, mode)
- Response in days for planned intake from time of first contact (range, mean, median, mode)

In-Home Services and Supports

- Average number of hours percentage total

- Average number of planned supports
- Average number of people served in planned supports
- Average number of hours with emergency supports
- Average number of hours in planned supports
- Total number of people served in planned supports
- Total number of people served in emergency supports
- Recidivism rates for planned and emergency: range, mean, median and mode
- Total number of people served who live with their family (planned)
- Total number of people served who live with their family (emergency)
- Estimated travel time for individuals to get to respite who used services this year (range, mean, median, mode)
- Services provided at the home (list: provide mean, median and mode for all services)

Respite Services

- Average occupancy percentage total
- Average number of planned respite admissions
- Average number of people served in planned respite
- Average number of days in emergency respite per person
- Average number of days in planned respite per person
- Total number of people served in planned respite
- Total number of people served in emergency respite
- Recidivism rates for planned and emergency: range, mean, median and mode
- Total number of people served who live with their family (planned respite)

- Total number of people served who live with their family (emergency respite)
- Estimated travel time for individuals to get to respite who used services this year (range, mean, median, mode)

Outpatient Services

- Referral sources
- Descriptive analysis of: demographics, diagnosis, treatments provided and length of stay.
- Hours of support and services provided (range, mean, median and mode)

Services for Individuals Discharged from State Facilities

- Number of individuals identified for planning
- Number of people who have been discharged
- Descriptive analysis of START services provided

Other Services Provided

- Training (descriptive analysis: type, who provided, number of hours)
- Consultation descriptive analysis: (type, who provided, number of hours)